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BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **KENNETH WAYNE ERICKSON** 745 Santa Ana Los Banos, California 93635 **Registered Nurse License No. 624153** **Nurse Practitioner Certificate No. 14456** **Nurse Practitioner Furnishing Certificate No. 14456** Respondent.	Case No. 2013-352 **A C C U S A T I O N**

Louise R. Bailey, M.Ed., RN ("Complainant") alleges:

PARTIES

1. Complainant brings this Accusation solely in her official capacity as the Executive Officer of the Board of Registered Nursing ("Board"), Department of Consumer Affairs.

Registered Nurse License

2. On or about August 13, 2003, the Board issued Registered Nurse License Number 624153 to Kenneth Wayne Erickson ("Respondent"). The license was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2012, unless renewed.

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Nurse Practitioner Certificate

3. On or about August 19, 2003, the Board issued Nurse Practitioner Certificate Number 14456 to Respondent. The certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2012, unless renewed.

Nurse Practitioner Furnishing Certificate

4. On or about October 24, 2003, the Board issued Nurse Practitioner Furnishing Certificate Number 14456 to Respondent. The certificate was in full force and effect at all times relevant to the charges brought herein and will expire on December 31, 2012, unless renewed.

STATUTORY AND REGULATORY PROVISIONS

5. Code section 2761 states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, the following:

(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions."

6. Code section 2762 states, in pertinent part:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do the following:

(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

7. California Code of Regulations, title 16, section 1442, states:

"As used in Section 2761 of the code, 'gross negligence' includes an extreme departure from the standard of care which, under similar circumstances, would have ordinarily been exercised by a competent registered nurse. Such an extreme departure means the repeated failure to provide nursing care as required or failure to provide care or to exercise ordinary precaution in a single

situation which the nurse knew, or should have known, could have jeopardized the client's health or life."

8. California Code of Regulations, title 16, section 1443, states:

"As used in Section 2761 of the code, 'incompetence' means the lack of possession of or the failure to exercise that degree of learning, skill, care and experience ordinarily possessed and exercised by a competent registered nurse as described in Section 1443.5."

COST RECOVERY

9. Code section 125.3 provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

10. "Dilaudid," a brand of hydromorphone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(J).

11. "Vicodin" is a compound consisting of 5 mg. hydrocodone bitartrate, also known as dihydrocodeinone, a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4), and 500 mg. acetaminophen per tablet.

12. "Vicodin ES" is a compound consisting of 7.5 mg. hydrocodone bitartrate, also known as dihydrocodeinone, a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4), and 750 mg. acetaminophen per tablet.

13. "Percocet," a brand of oxycodone, is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M).

14. "Norco" is a compound consisting of 10 mg. hydrocodone bitartrate, also known as dihydrocodeinone, a Schedule III controlled substance as designated by Health and Safety Code section 11056(e)(4), and 325 mg. acetaminophen per tablet.

15. "Oxycodone" is a Schedule II controlled substance as designated by Health and Safety Code section 11055(b)(1)(M).

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FIRST CAUSE FOR DISCIPLINE

(Falsified, Made Incorrect or Inconsistent Entries In Hospital or Patient Records)

16. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct as defined in Code section 2762(e), in that between June 18, 2007, and May 8, 2008, while employed as a nurse practitioner in the ambulatory care unit at Escalon Community Health Center, located in Escalon, California, Respondent falsified, made grossly incorrect, grossly inconsistent or unintelligible entries in hospital or patient records in the following respects:

Patient A:

a. On or about December 5, 2007, Respondent prescribed Patient A 180 tablets of Vicodin ES with three (3) refills of 180 tablets each refill, but failed to document the prescribing of the refills for that medication in any hospital or patient record.

b. On or about January 31, 2008, Respondent prescribed Patient A 180 tablets of Vicodin ES with two (2) refills of 180 tablets each refill, but failed to document the prescribing of the refills for that medication in any hospital or patient record.

Patient B:

c. On or about June 18, 2007, Respondent prescribed Patient B 90 tablets of Vicodin, but failed to document the prescribing of that medication in any hospital or patient record.

d. On or about September 4, 2007, Respondent prescribed Patient B 180 tablets of Vicodin with three (3) refills of 180 tablets each refill, but failed to document the prescribing of that medication in any hospital or patient record.

e. On or about October 9, 2007, Respondent prescribed Patient B 180 tablets of Hydrocodone with three (3) refills of 180 tablets each refill, but failed to document the prescribing of that medication in any hospital or patient record.

f. On or about November 26, 2007, Respondent prescribed Patient B 100 tablets of Vicodin with six (6) refills of 100 tablets each refill, but failed to document the prescribing of that medication in any hospital or patient record.

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g. On or about January 14, 2008, Respondent prescribed Patient B 180 tablets of Vicodin with one (1) refill of 180 tablets, but failed to document the prescribing of that medication in any hospital or patient record.

h. On or about March 6, 2008, Respondent prescribed Patient B 180 tablets of Vicodin with one (1) refill of 180 tablets, but failed to document the prescribing of that medication in any hospital or patient record.

Patient C:

i. On or about April 18, 2008, Respondent prescribed Patient C Oxycontin and Percocet, but failed to document the prescribing of those medications in any hospital or patient record.

Patient E:

j. On or about July 31, 2007, Respondent prescribed Patient E 250 tablets of Norco, but failed to document the prescribing of that medication in any hospital or patient record.

k. On or about October 9, 2007, Respondent prescribed Patient E 90 tables of Oxycodone, but failed to document the prescribing of that medication in any hospital or patient record.

l. On or about October 26, 2007, Respondent prescribed Patient E 240 tablets of Norco, but failed to document the prescribing of that medication in any hospital or patient record.

m. On or about November 6, 2007, Respondent prescribed Patient E 90 tablets of Oxycodone, but failed to document the prescribing of that medication in any hospital or patient record.

n. On or about December 4, 2007, Respondent prescribed Patient E 120 tablets of Norco, but failed to document the prescribing of that medication in any hospital or patient record.

o. On or about December 4, 2007, Respondent prescribed Patient E 90 tablets of Oxycodone, but failed to document the prescribing of that medication in any hospital or patient record.

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p. On or about January 25, 2008, Respondent prescribed Patient E 90 tablets of Dilaudid, but failed to document the prescribing of that medication in any hospital or patient record.

q. On or about February 19, 2008, Respondent prescribed Patient E 90 tablets of Oxycodone, but failed to document the prescribing of that medication in any hospital or patient record.

r. On or about March 1, 2008, Respondent prescribed Patient E 120 tablets of Norco, but failed to document the prescribing of that medication in any hospital or patient record.

s. On or about April 1, 2008, Respondent prescribed Patient E 120 tablets of Norco, but failed to document the prescribing of that medication in any hospital or patient record.

t. On or about April 3, 2008, Respondent prescribed Patient E 90 tablets of Oxycodone, but failed to document the prescribing of that medication in any hospital or patient record.

u. On or about May 1, 2008, Respondent prescribed Patient E 120 tablets of Norco, but failed to document the prescribing of that medication in any hospital or patient record.

v. On or about May 8, 2008, Respondent prescribed Patient E 49 tablets of Vicodin, but failed to document the prescribing of that medication in any hospital or patient record.

SECOND CAUSE FOR DISCIPLINE

(Gross Negligence)

17. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of unprofessional conduct, in that between May 17, 2007, and April 21, 2008, while employed as a nurse practitioner in the ambulatory care unit at Escalon Community Health Center, located in Escalon, California, Respondent was grossly negligent in the following respects:

Patient A:

a. Respondent prescribed excessive amounts of Vicodin ES to the patient without an appropriate evaluation, supervision, monitoring, and follow-up care.

b. Respondent failed to review the patient's records and individual circumstances prior to refilling narcotic prescriptions.

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c. Respondent prescribed Vicodin ES in too short of time had the patient taken the medication as prescribed.

d. Respondent deliberately and intentionally failed to document narcotic medications prescribed and/or refilled in the patient's chart to avoid having to obtain the supervising physician's (Dr. Peterson) authorization, thereby putting the patient at risk, in that the patient's chart failed to reflect the patient's true history.

e. Respondent practiced outside his scope by failing to consult with a supervising physician prior to prescribing more than 120 pills per patient per month.

Patient B:

f. Respondent prescribed excessive amounts of Vicodin to the patient without an appropriate evaluation, supervision, monitoring, and follow-up care.

g. Respondent prescribed Vicodin in too short of time had the patient taken the medication as prescribed.

h. Respondent deliberately and intentionally failed to document narcotic medications prescribed and/or refilled in the patient's chart to avoid having to obtain the supervising physician's (Dr. Peterson) authorization, thereby putting the patient at risk, in that the patient's chart failed to reflect the patient's true history.

Patient C:

i. Respondent prescribed excessive amounts of Oxycontin and Percocet to the patient.

j. Respondent prescribed Oxycontin and Percocet in too short of time had the patient taken the medication as prescribed.

k. Respondent deliberately and intentionally failed to document narcotic medications prescribed and/or refilled in the patient's chart to avoid having to obtain the supervising physician's (Dr. Peterson) authorization, thereby putting the patient at risk, in that the patient's chart failed to reflect the patient's true history.

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l. Respondent instructed the patient not to tell anyone that he intentionally omitted documenting the Oxycontin and Percocet prescriptions in the chart, thereby violating the ethical standards of the nursing practice.

Patient D:

m. Respondent prescribed excessive amounts of Oxycontin and Percocet to the patient without the appropriate evaluation, supervision, monitoring, and follow-up care.

n. Respondent prescribed Oxycontin and Percocet in too short of time had the patient taken the medication as prescribed.

o. Respondent failed to comply with the Standardized Procedures - Prescribing Guidelines by failing to obtain the supervising physician's (Dr. Peterson) authorization prior to prescribing Schedule II narcotics. In addition, Respondent practiced outside his scope by failing to consult with a supervising physician prior to prescribing more than 120 pills per patient per month.

Patient E:

p. Respondent prescribed excessive amounts of narcotic medications to the patient.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

18. Respondent is subject to discipline under Code section 2761(a)(1), on the grounds of unprofessional conduct, in that between May 17, 2007, and April 21, 2008, while employed as a nurse practitioner in the ambulatory care unit at Escalon Community Health Center, located in Escalon, California, he was incompetent by failing to exercise the degree of learning, skill, care, and experience ordinarily possessed and exercised by a competent nurse, as more particularly set forth above in paragraph 17.

FOURTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

19. Respondent is subject to discipline under Code section 2761(a), on the grounds of unprofessional conduct, in that between May 17, 2007, and April 21, 2008, while employed as a nurse practitioner in the ambulatory care unit at Escalon Community Health Center, located in

Escalon, California, Respondent demonstrated unprofessional conduct, as more particularly set forth above in paragraph 17.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nurse License No. 624153, issued to Kenneth Wayne Erickson;

2. Revoking or suspending Nurse Practitioner Certificate Number 14456, issued to Kenneth Wayne Erickson;

3. Revoking or suspending Nurse Practitioner Furnishing License Number 14456, issued to Kenneth Wayne Erickson;

4. Ordering Kenneth Wayne Erickson to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Code section 125.3; and,

5. Taking such other and further action as deemed necessary and proper.

DATED: November 1, 2012

for LOUISE R. BAILEY, M.ED., RN
Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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